STATE OF DELAWARE

Division of Development Disabilities Services Task Force

Meeting Minutes – September 11, 2019

Senator Stephanie L. Hansen, Co-Chair, called the meeting to order at 1:00 p.m. Those present were Senator Anthony Delcollo via telephone, Marissa Catalon, Deputy Director for the Division of Development Disabilities Service (DDDS), Laura Strmel, Director of Employment Services at St. John's, Gary Cassedy, Vice-President of Programs with Easter Seals, Bianca Allegro, Director of Delaware Mentor, Michele Mirabella, Director of Residential Services for Chimes Delaware, Albert Anderson, Jr., Current Volunteer, former DDDS employee, Terry Hancharick, Chair of the Advisory Council for DDDS, Vice-Chair of the State Council for Persons with Disabilities, Kyle Hodges, Policy Director for the State Council for Persons with Disabilities, Rita M. Landgraf, University of Delaware and former Cabinet Secretary for Department of Health and Social Services, Allan R. Zaback, Wilmington University, Chair of the Administration of Human Services Graduate Program, Retired former Director of the State Division of Aging, and former DDDS employee., Representatives Kendra Johnson and Kevin S. Hensley and Roy LaFontaine III, were not present. A quorum was met.

Co-Chair Hansen welcomed everyone and asked for introductions of each person present and the agency they represent. Afterwards, Co-Chair Hansen restated the purpose and goal of the task force.

Co-Chair Hansen continued with the approval of the minutes. A motion was made to accept the minutes by Rita Landgraf and seconded by Laura. Strmel. All in favor, no opposed, Representatives Kevin Hensley and Kendra Johnson, and Roy LaFontaine were absent, the motion carried.

Co-Chair Hansen moved to item 3 on the agenda, the discussion of the investigation process in the proposed regulations. DDDS had supplied a flow chart visualizing the process and Co-Chair Hansen provided written notes which outlined her understanding of the flow chart and stated her desire to see consistency between the regulations and the information on the flow chart provided by DDDS. Co-Chair Hansen called on Marissa Catalon to explain section 5 of the proposed regulations with regard to the DDDS flow chart. Ms. Catalon stated that the information highlighted in orange on the DDDS supplied flow chart pertained to section 5. Co-Chair Hansen questioned why policy memorandum 46 ("PM 46") was present on the DDDS flow chart and absent in section 5 of the regulations. Ms. Catalon explained that PM 46 is a part of the process that would happen within DDDS, and the information given in the flow chart is not that detailed in regards to the process within DDDS. Rita Landgraf asked how the policy memorandum overlays

with the policy regulation. Marissa Catalon stated that the policy memorandum addresses specific incidents and the regulation addresses how DDDS is to treat those incidents. Rita Landgraf followed up asking where PM 46 was in the regulations in the event that someone needed to look for that information, adding that maybe this could be a recommendation to have a document cross referenced with the regulations themselves so that the flow chart and the regulations align more closely with one another. Laurel Strmel stated that her prior attempt to create uniformity proved to be difficult, but the information provided was helpful to have, due to some ongoing confusion surrounding policies and processes. Co-Chair Hansen stated that it's important for all applicable information to be stated in a clear way for providers to understand. Marissa Catalon stated that outside of the policies and regulations, there are trainings available for providers to understand the expectations.

Co-Chair Hansen moved the discussion to section 6 of the proposed regulations, reporting of incidents. Marissa Catalon indicated that section 6 was depicted on the top row of the DDDS flow chart. Co-Chair Hansen stated that section 6 was confusing as it talks about reportable incidents and its subsets whereas section 6.1 speaks on certain reportable incidents, which could be interpreted as a critical incident. Marissa Catalon stated she would go over the regulations to see how the language could be modified.

Gary Cassedy stated that, in the proposed regulations, a reasonable cause triggers the investigation process. There was no definition of reasonable cause in the proposed regulations. The beginning of section 6 stated that there was a need for reasonable belief or cause to start the investigation, but there was not a definition of what constitutes a reasonable cause.

Bianca Allegro added that providers have been directed to report an incident in order to have DDDS determine if the incident fell under PM 46. Because of this direction, there was no room to interpret what reasonable cause would mean. If an event occurs that could be seen as a reportable incident, it would be reported to err on the side of caution. That way, documentation exists to prevent any repercussions in the future.

Co-Chair Hansen stated that a possible recommendation related to section 6 could be identifying the need for guidelines or policy language on what may trigger "reasonable cause" and exploring what that criteria could look like.

Rita Landgraf suggested the task force look at evidence-based "best practice" measures in this area. Delaware is not the first to have these conversations surrounding vulnerable populations, so taking a look at the best standard of care could be a starting point.

Gary Cassedy responded that the current system has evolved to consider the best practice standard as the most risk averse. With risk being a constant factor, any regulations and policies should avoid the pitfall of regulating out of the fear of risks.

Senator Delcollo suggested that to avoid confusion over what actions are deemed correct to take, it would be helpful to delineate between burden of proof regarding accusations that lead to disciplinary action against a provider versus the standard of care that needs to be complied with.

Michele Mirabela asked for clarification regarding Division investigators being trained to recognize PM 46 incidents. Marissa Catalon confirmed that investigators are trained using the standard curriculum that has been used continuously over the years. Co-Chair Hansen asked if a recommendation could result from the discussion. Rita Landgraf suggested looking at how regulatory requirements related to already established processes outlined in PM 46 and identify any gaps within the processes.

Lisa Green of the Salvation Army expressed concern that DDDS was moving away from PM 46 and instead adopting those processes into the new regulations.

Co-Chair Hansen moved the discussion to section 7.0 of the regulations, who to notify that an investigation has been opened and/or completed. Marissa Catalon showed where section 7.0 appeared in the DDDS flow chart. Co-Chair Hansen pointed out that section 7.2 dealt with investigator assignment and that DDDS would mail a notification to the recipient and guardian within two days. Marissa Catalon clarified that two notifications were sent: one informing that an incident was received, and a follow-up notification indicating if there was intent to investigate. Marissa Catalon additionally clarified that the second notification was not reflected in the current DDDS flow chart.

Laura Strmel expressed confusion over some of the language in sections 7.1 and 7.2 relating to notifications. Section 7.1 only mentioned critical incidents while 7.2 mentioned both critical and non-critical incidents.

Co-Chair Hansen read from section 7 of the proposed regulations outlining the notification process beginning with written notification to the recipient and guardian within one day. An investigator was then assigned with DDDS providing written notification within two days. The Office of Incident Resolution notifies provider, DDDS, and the case manager followed by DHSS, DHCQ, DOJ, law enforcement (when necessary). Following the completion of the investigation, an incident summary report is generated. Once approved by DDDS and the Office of Incident Resolution, DDDS notifies, in writing, the provider, recipient, and guardian the outcome of the investigation. Marissa Catalon clarified that the flow chart is high level and does not provide that level of detail within the visual chart. Co-Chair Hansen stated it would be beneficial for providers and users of the services to have a detailed version of these processes to clear up any possible confusion. Marissa Catalon agreed and clarified that when the flow chart was created, it was intended to be used internally within DDDS and additional tools could be created and shared with providers, families, and service recipients to make the process easier to understand.

Theresa Hancharick expressed concern with using the term guardian. Some parents and caretakers may have a different legal standing such as surrogate decision maker. Laura Strmel suggested

finding additional language to clarify the intent of using a legal term like guardian. Bianca Allegro commented that providers are put in a difficult positions since the majority of individuals are their own guardian but have involved family members. When an occurrence takes place, the providers, not DDDS, are put in a position of denying information, which may frustrate and concern the family member. It would be beneficial to find a way to inform an involved family member. Marissa Catalon stated that it is a delicate balancing act because many individuals receiving services are able to make their own decisions and some do not want certain people involved in their decision-making process, and that is their right.

Kyle Hodges suggested a working group look at the proposed regulations and identify issues as opposed to the entire task force. Co-Chair Hansen expressed the need for a group to continue after the task force concludes and focus on the issues identified by this task force. Marissa Catalon indicated that various working groups have worked over the last few years on proposed regulations, and DDDS is still soliciting public comment and involvement in that process. Theresa Hancharick expressed the desire for families and service recipients to be at the table. Laura Strmel stated that she would like to see a timeline established for the adoption of these regulations, so training could begin and the ambiguity and confusion surrounding draft policies could be avoided as much as possible.

Co-Chair Hansen moved on to section 8.0 of the proposed regulations involving the investigation methods. Since the issue of collaborative, concurrent, and sequential investigations has been an ongoing concern, Co-Chair Hansen invited state solicitor Aaron Goldstein to speak on peer review privilege as it related to this section and a 2015 letter the Department of Justice sent in response to a FOIA request.

Aaron Goldstein provided documentation of relevant case law regarding the peer review privilege that exists in Delaware law. Aaron Goldstein explained that the response to the FOIA request in 2015, which cited the peer review privilege, does not automatically apply to all cases and situations. Peer review privilege is one of the strongest privilege laws on the books because it states explicitly that items covered are not discoverable and do not have to be identified. No privilege is absolute, but the peer review is stronger than most. Evoking the privilege is the prerogative of the party that holds the information. When the privilege has been challenged in court, the courts have repeatedly said that while transparency is important, advancement in health care should allow a zone of privacy for health care providers and regulators to operate within. How that zone of privacy is defined should be the job of the state and policymakers to figure out as long as it meets the criteria outlined in the statute (title 24 of Delaware Code). Currently, the law strikes a balance with regards to private information. The PM 46 process is considered within the peer review privilege. Co-Chair Hansen and Bianca Allegro asked about performing investigations at the same time being allowable. Aaron Goldstein stated that how that privilege is structured and deployed is a policy choice by the state and would not be part of a DOJ or court interpretation. Aaron Goldstein pointed out a 5 day period in the proposed regulations before a provider investigation can begin following an investigation closure letter from DDDS outlining facts and findings of investigation. Bianca

Allegro stated that, historically, 5 days has become 30 or more days, and, typically, providers want to begin fact-finding and information gathering without a 5-day delay in order to take immediate action on any outstanding issues, especially if corrective action measures are a result.

Co-Chair Hansen stated that staff looked at what other states did regarding collaborative, concurrent, and sequential investigations. Regulations from Pennsylvania, Kentucky, and Montana were provided to task force members. Marissa Catalon stated that DDDS does periodically survey other states and how they administer services, and pointed out that if the regulations from Pennsylvania, Kentucky, and Montana were adopted prior to the release of the Joint Inspector General Report in 2018, those guidelines would not be reflected and may be in the process of updating those regulations to reflect the report's recommendations.

Co-Chair Hansen inquired on DDDS's position on concurrent, sequential, and collaborative investigations of non-criminal incidents. Marissa Catalon stated that the recommendation from the Joint Inspector General Report is for states to independently investigate based on the type of incident. It also outlined the categories and types of incidents that could be deferred to the provider to investigate. DDDS is currently looking to incorporate those recommendations into their process and utilize law enforcement methods to protect the integrity of their independent investigation and primary witness interviews. After completion of those interviews, no more than 5 days, DDDS would notify a provider so an internal investigation could begin.

Co-Chair Hansen asked if the Joint Inspector General Report discussed what information could be shared. Marissa Catalon responded no. Co-Chair Hansen asked if that would be a policy decision made by DDDS. Marissa Catalon answered that the decision would be consistent with the policy procedure outlined by Aaron Goldstein and elaborated that correspondence of investigative information being shared exists and if there is an inconsistency regarding what information is being shared versus not being shared, DDDS would like to be made aware so it can be addressed.

Co-Chair Hansen stated that a number of sources have provided a large amount of new information. Members should take time and familiarize themselves with the landscape as outlined by these sources.

Co-Chair Hansen returned to the discussion regarding section 8.0 of the proposed regulations and read through the following timeline process: within two days of an incident being reported, OIR conducts preliminary investigation and assigns investigator. When the preliminary investigation concludes, a decision is made as to whether or not a subsequent investigation is required. If a DDDS investigator is assigned to a subsequent investigation, the provider is informed within two days of the assignment and the provider is prohibited from conducting its own investigation until the DDDS investigation is completed as outlined in section 8.3. Co-Chair Hanson then questioned where this process was captured in the DDDS flow chart. Marissa Catalon pointed out that the flow chart was not clear on time frames and clarification would be provided and reflected in the next version of the flow chart.

Gary Cassedy asked for clarification on section 8.2.4. Marissa Catalon stated that in the incident management system, when the assignment occurs, the investigator is alerted to the case through the system. Gary Cassedy pointed out that in the Harmony management system, no alert occurs. A user must log in to check for new notifications. Marissa Catalon responded that DDDS is more focused on investing resources into how to utilize the electronic key record system that may have some of these functions but, to date, have not been used.

Co-Chair Hansen suggested that a recommendation could be creating a provider notification in a case management system; either upgrading or replacing Harmony or utilizing the current electronic key record system in that capacity. Michele Mirabella commented that she hopes Harmony is not expanded at the providers' expense as providers already pay a user fee to access the Harmony system.

Co-Chair Hansen concluded discussion on section 8.0 and stated that the next meeting would begin with section 9.0

The meeting concluded at 3:03pm.

Respectfully prepared by:

Amanda McAtee and Mark Brainard, Jr., JLOSC Analysts, Joint Legislative Oversight and Sunset Committee.

Access to the audio recording of this proceeding is available upon request.